



## ***Texas Department of Insurance***

### ***Division of Workers' Compensation***

Medical Fee Dispute Resolution, MS-48

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## ***MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION***

### ***GENERAL INFORMATION***

#### **Requestor Name and Address**

TWELVE OAKS MEDICAL CENTER  
C/O FRANCIS ORR & TOTUSEK, LLP  
103 EAST VIRGINIA SUITE 203  
MCKINNEY TX 75069

#### **Carrier's Austin Representative Box**

#19

#### **MFDR Date Received**

JULY 31, 2006

#### **Respondent Name**

ZURICH AMERICAN INSURANCE CO

#### **MFDR Tracking Number**

M4-06-7300-01

### ***REQUESTOR'S POSITION SUMMARY***

**Requestor's Position Summary Dated July 28, 2006:** "...Twelve Oaks Medical Center billed its usual and customary charges for its services. The total sum billed was \$58,928.88...Per Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%...the fees paid by Zurich American Insurance Company do not conform to the reimbursement section of Rule 134.401...it is the position of Twelve Oaks Medical Center that all charges relating to the admission of [Claimant] are due and payable as provided for under Texas law and the Rules of the Division, as currently adopted and published at 28 TAC §134.400, *et seq.*"

**Requestor's Supplemental Position Summary Dated June 22, 2007:** "This firm and the undersigned have been retained by Twelve Oaks Medical Center...in reference to the above-captioned workers' compensation medical dispute resolution matter."

**Requestor's Supplemental Position Summary Dated November 29, 2011:** "The purpose of the Stop-Loss Exception is to ensure adequate access to medical care for unusually extensive and unusually costly services...GEBRS, on behalf of TOMC, contends that the above referenced account and submitted claim meets the threshold requirements for payment under the 'stop-loss exception' in the amount of 75% of total audited charges less a contractual discount under the First Health network contract of 8%. Accordingly, TOMC has not been reimbursed appropriately by the carrier, Zurich American Insurance Co, and GEBFS is owed an additional sum of \$28,163.84."

**Amount in Dispute:** \$28,163.84

### ***RESPONDENT'S POSITION SUMMARY***

**Respondent's Position Summary Dated August 22, 2006:** "Requestor billed a total of \$58,928.88. The Requestor asserts it is entitled to reimbursement in the amount of \$44,196.66, which is 75% of the total charges... To qualify for stop loss, the services provided by the hospital must be unusually costly to the hospital as opposed to unusually priced to the carrier...There is no evidence submitted by the hospital demonstrating that the services provided by the hospital were unusually extensive...there is no evidence that the services provided by the hospital were unusually costly to the hospital..."

**Respondent's Supplemental Position Summary Dated September 12, 2011:** "Respondent submits this Respondent's Post-Appeal Supplemental Response as a response to and incorporation of the Third Court of Appeals Mandate in Cause No. 03-07-00682-CV...Based upon Respondent's initial and all supplemental responses, and in accordance with the Division's obligation to adjudicate the payment, in accordance with the

Labor Code and Division rules, Requestor has failed to sustain its burden of proving entitlement to the stop-loss exception. The Division must conclude that payment should be awarded in accordance with the general *per diem* payment in accordance with 28 Texas Administrative Code §134.401 (repealed)..."

**Responses Submitted by:** Flahive, Ogden & Latson

### **SUMMARY OF FINDINGS**

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
August 1, 2005 through August 3, 2005	Inpatient Hospital Services	\$28,163.84	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

#### **Explanation of Benefits**

- TX 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
- TX W1 – Workers Compensation State Fee Schedule Adjustment.
- W1 01 – RC 01 – The charge for the procedure exceeds the amount indicated in the fee schedule.
- A46 – ADDITIONAL ALLOWANCE PER MCSC M.D./R.N. REVIEW
- REVIEWED PER TX WC FEE SCHEDULE AND RN MEDICAL REVIEW URA04502 PLEASE PROVIDE AN ITEMIZED BILL AND VENDOR INVOICES FOR IMPLANT REIMBURSEMENT. NO DOCUMENTATION WAS RECEIVED TO SUPPORT STOP LOSS CRITERIA OF UNUSUALLY EXTENSIVE SERVICES.

#### **Issues**

1. Did the audited charges exceed \$40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

#### **Findings**

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 *Texas Register* 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The

documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges *in this case* exceed \$40,000; whether the admission and disputed services *in this case* are unusually extensive; and whether the admission and disputed services *in this case* are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection..." 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "...to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "...Audited charges are those charges which remain after a bill review by the insurance carrier has been performed..." Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal \$58,928.88. The Division concludes that the total audited charges exceed \$40,000.
2. 28 Texas Administrative Code §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The Third Court of Appeals' November 13, 2008 opinion states that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services" and further states that "...independent reimbursement under the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." The requestor in its position statement states that "Per Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%." This statement does not meet the requirements of 28 Texas Administrative Code §134.401(c)(2)(C) because the requestor presumes that the disputed services meet Stop-Loss, thereby presuming that the admission was unusually extensive. The division concludes that the requestor failed to meet the requirements of 28 Texas Administrative Code §134.401(c)(2)(C).
3. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. The requestor's position statement does not address how this inpatient admission was unusually costly. The requestor does not provide a reasonable comparison between the cost associated with this admission when compared to similar surgical services or admissions, thereby failing to demonstrate that the admission in dispute was unusually costly. The division concludes that the requestor failed to meet the requirements of 28 Texas Administrative Code §134.401(c)(6).
4. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements*. The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.
  - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of \$1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission..." The length of stay was two days. The surgical per diem rate of \$1,118.00 multiplied by the length of stay of two days results in an allowable amount of \$2,236.00.
  - 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)."
  - A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at \$17,035.00 on the original bill and \$17,479.94 on the reconsideration bill. A review of the itemized statement finds the implantables listed on the itemized statement had a total charge of \$17,479.94.
  - The Division finds the total allowable for the implants billed under revenue code 278 is:

Description of Implant per Itemized Statement	Quantity	Cost Per Unit	Cost + 10%
Pin Steinman II	4	\$55.00	\$242.00
FMRL XRSS SCTN	1	\$522.00	\$574.20
Infuse Medium Kit	1	\$4,490.00	\$4,939.00
18mm Dowel	1	\$513.00	\$564.30
Washer	2	\$21.50	\$47.30
Can BN SCW 6.5	1	\$26.25	\$28.88
TOTAL			\$6,395.68

- 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than \$250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed \$251.00/unit for Kanamycin 1GM, and \$636.25/unit for Hespan 500ML. The requestor did not submit documentation to support what the cost to the hospital was for these items billed under revenue code 250. For that reason, additional reimbursement for these items cannot be recommended.

The division concludes that the total allowable for this admission is \$8,631.68. The respondent issued payment in the amount of \$12,493.50. Based upon the documentation submitted no additional reimbursement can be recommended.

### **Conclusion**

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed \$40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount*, and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
04/18/2013  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**